FOLLOW-UP REPORT ON THE USE OF SECLUSION AND RESTRAINT AT WESTERN STATE HOSPITAL

COMMONWEALTH OF VIRGINIA
Virginia Office for Protection and Advocacy
202 N. 9th Street, 9th Floor
Richmond, VA 23219
(804) 225-2042

BACKGROUND AND PURPOSE

In April 2001, the Virginia Office for Protection and Advocacy (VOPA), then known as the Department for Rights of Virginians with Disabilities (DRVD), published a report on the use of seclusion and restraint at Western State Hospital (WSH), an inpatient psychiatric facility operated by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). In the report, which is available on VOPA's web site, www.vopa.state.va.us, VOPA identified several areas of concern and made recommendations to address those concerns. DMHMRSAS submitted a response to the report. That response is also posted on the web site. (Note: On July 16, 2002, DRVD redesignated to the VOPA, an independent state agency. For continuity, the information contained in this study report, is reported to have been accomplished or undertaken by VOPA.)

VOPA's initial report from April 2000, utilizing data from January – March 2000, cited the following issues:

(1) While at the time of the initial study, WSH had decreased its use of seclusion and restraint over the previous 3 years, facility staff did not consistently follow WSH's internal policy, including its policy of only utilizing seclusion and restraint following attempts to intervene in a less restrictive manner.

(2) WSH failed to adhere to its policy regarding the types of seclusion and restraint to be used, resulting in many instances in which more restrictive methods of seclusion and restraint were used than warranted.

(3) WSH instigated seclusion and restraint methods in response to non-emergency situations.

(4) Patients were often not informed of the reason(s) they were being secluded or restrained or the criteria for release from seclusion and restraint, in violation of WSH policy, thus decreasing or defeating any value of the method except as a punishment.

This follow-up report presents an analysis of data regarding WSH's use of seclusion and restraint methods collected and analyzed by VOPA since the issuance of the initial report and identifies areas in which WSH has improved and areas of concern that remain.

SUMMARY OF FINDINGS

WSH has shown real improvement in following its policy regarding the use of seclusion and restraint methods and made marked efforts to ensure that the use of those methods are a last, rather than first, resort. However, our follow-up study reveals ongoing issues related to the use of seclusion and restraint at that facility, some of which represent potentially disturbing new trends.

Issues, which are of significant concern, are as follows:

(1) WSH's use of restraint methods has actually increased since the initial study. The average percentage of the hospital census restrained was higher in fiscal year (FY) 2001-02 (through April 2002) than in FY 1997-98, 1998-99, 1999-2000 and 2000-01. Actual restraint hours are at their highest level since FY 1998 after a sharp decrease between FY 1998 and FY 1999.

(2) WSH's use of seclusion has actually increased since the initial study. The average percentage of the hospital census secluded is at its highest level since FY 1998 following continued decreases in its use between 1997 and 2000. Average seclusion hours were up slightly between FY 2000 (the initial study timeframe) and the current year.

(3) WSH still fails to adequately communicate with its patients during and after using seclusion and restraint methods.

(4) While significantly improved in terms of percentage of instances of unwarranted use, in the data reviewed, WSH had one instance in which the use of seclusion and restraint was clearly inappropriate and not warranted.

There have also been commendable improvements in certain areas since publication of our initial study. These are as follows:

(1) WSH has increased its use of less restrictive techniques before utilizing seclusion and restraint.

(2) WSH has decreased its use of the most restrictive forms of restraint (4- and 6-point restraints).

METHODOLOGY

VOPA initially studied aggregate data for the use of seclusion and restraint for FY 2000-01 and 2001-02. These data set forth, by month, the percentage of WSH patients who had been subjected to seclusion and restraint and the total number of hours in which WSH patients had been secluded or restrained.

In the original report, VOPA analyzed a total of 35 incidences of seclusion and/or restraint during the months of January – March 2000 (see previous report for additional detail on that study's methodology and data analysis). In its follow-up study, VOPA requested and received the names of WSH patients who had been secluded or restrained from July 1, 2001 through November 28, 2001.[1] July 1, 2001 was the date at which DMHMRSAS was to begin implementation of a new monitoring system designed to assure that WSH utilized seclusion or restraint interventions only as a last resort.

[1] The publication of this report was delayed due to a disagreement between VOPA and DMHMRSAS over VOPA's authority to access certain DMHMRSAS records. DMHMRSAS initially contended that it did not have to, and would not, provide the records to VOPA. VOPA contended that it had the authority and ability to access the records under Virginia and federal law and threatened legal action to require DMHMRSAS to provide the records. Subsequently, DMHMRSAS provided the records and this report was published.

Discussion of this new monitoring instrument was included in the DMHMRSAS response to our April 2001 study report.

In the current study, 36 individuals were identified as having been secluded and/or restrained for the 5-month period studied. VOPA eliminated data regarding patients who were restrained for transportation purposes only or for patients who had been discharged, thereby reducing the number of patients studied to 17. As in the first study, VOPA staff visited WSH and interviewed those persons identified. The interviews consisted of questions concerning the behaviors that led to the seclusion and restraint, the process of being placed in seclusion and restraint, their actions, and the actions of WSH staff while they were secluded and/or restrained.

Patients who had the requisite capacity were asked to sign a release for VOPA to receive and review their records. VOPA sent letters requesting consent to the Authorized Representatives (ARs) of those individuals who lacked the capacity to provide it. VOPA received consent from either the patient or the AR in 12 cases (70.58% of the initial group of 17 persons interviewed). This enabled VOPA to conduct a detailed review of 50 episodes of seclusion or restraint usage. WSH staff was cooperative in complying with VOPA's request for records.

VOPA staff collected data from the records of each incident of seclusion and restraint. The data were then analyzed using the VOPA Seclusion/Restraint Usage Review Survey, a form developed by VOPA for the initial survey. VOPA studied the incidents to determine whether WSH had complied with its own policies regarding seclusion and restraint and whether the areas of concern identified in VOPA's initial report had been addressed. This report represents a summary and analysis of that data.

FINDINGS

Findings are divided into subsections addressing: (a) WSH's aggregate use of seclusion and restraint from FY 2000-01 and 2001-02; (b) a comparison of aggregate data collected detailing

WSH's use of seclusion and restraint methods from FY 1997 to the present; (c) WSH's use of seclusion and restraint during the period from July to November 28, 2001 (the study period); (d) areas of improvement since the earlier study; and (e) areas of continuing concern.

A. Aggregate Use of Seclusion and Restraint in FY 2000-01 and FY 2001-02

(1) Restraint

Since the initial study, WSH's use of restraint has increased. Based on the data received and analyzed, the average percentage of the census restrained per month has increased by 20% (see Chart A); the average number of patient hours in restraint increased by 31% (see Chart B); and the average number of restraint episodes increased by 36% (see Chart C). However, on a more positive note, the average time spent in restraint per episode decreased by 6% (see Chart D).

Chart A

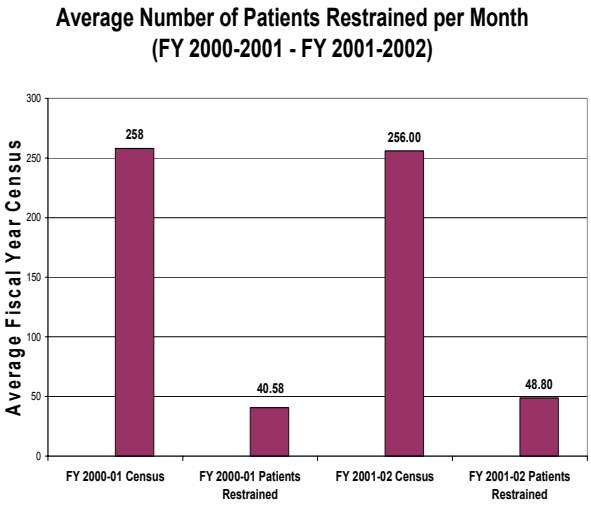


Chart B

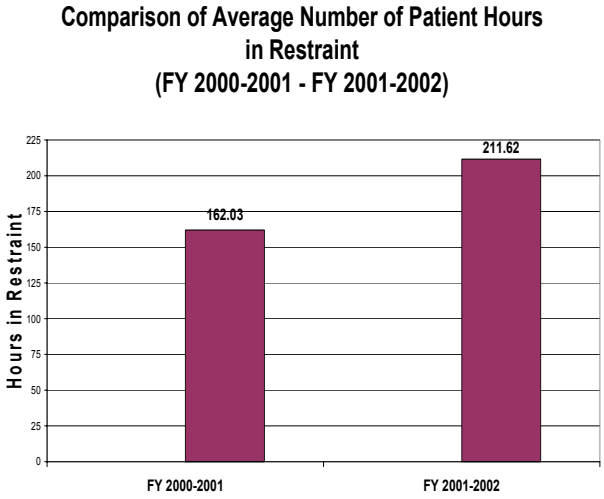


Chart C

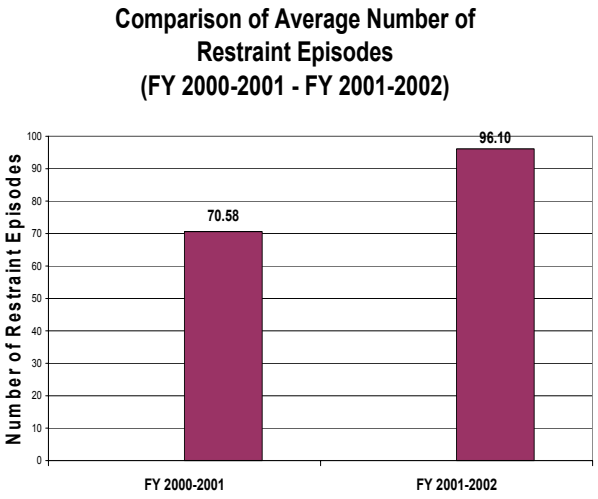
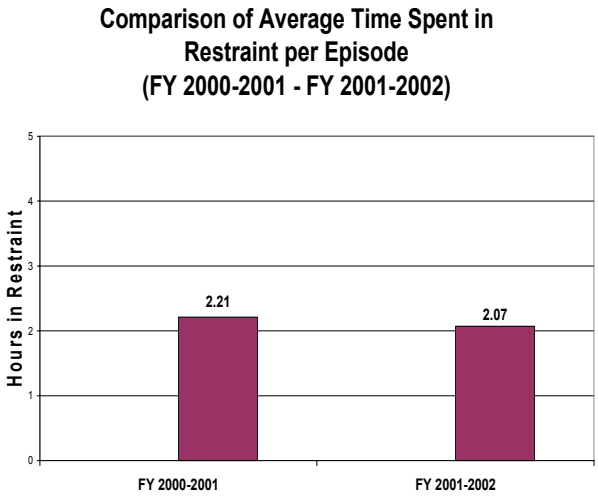


Chart D



Specifically, during FY 2000-01, the average number of patients restrained per month was 40.58 (15.73% of the average FY census), with a high of 61 (23.64%) in July 2000, and a low of 18 (6.98%) in December 2000. The average number of patient hours in restraint was 162.03 per month, with a high of 519 in March 2001, and a low of 35 in December 2000. The average number of restraint episodes was 70.58 per month, with a high of 115 in March 2001, and a low of 23 in December 2000. The average time spent in restraint per episode was 2.21 hours, with a high of 4.51 hours in March 2001, and a low of 1.21 hours in July 2000.

During FY 2001-02, the average number of patients restrained per month was 48.8 (19.06%), with a high of 63 (24.61%) in February 2002, and a low of 23 (8.98%) in April 2002. The average number of patient hours in restraint was 211.62 per month, with a high of 388.11 in November 2001, and a low of 93.14 in March 2002. The average number of restraint episodes was 96.1 per month, with a high of 122 in January 2002, and a low of 65 in March 2002. The average time spent in restraint per episode was 2.07 hours, with a high of 3.66 hours in November 2001, and a low of 1.04 hours in April 2002.

(2) Seclusion

Since the initial study, WSH's use of seclusion increased slightly. Based on the data received and analyzed, the average percentage of the census secluded per month increased by 31%; the average number of patient hours in seclusion also increased slightly, up less than 1%; the average time spent in seclusion decreased both in terms of the average (down 12%) and in terms of the highs and lows of utilization.

During FY 2000-01, the average number of patients secluded per month was 9.92 (3.84%) of the average FY census, with a high of 18 (6.98%) in May 2001, and a low of 3 (1.16%) in October 2000 (see Chart E). The average number of patient hours in seclusion was 56.06 per month, with a high of 162.08 in December 2000, and a low of 8.65 in October 2000 (see Chart F). The average number of seclusion episodes was 20 per month, with a high of 37 in March 2001, and a low of 5 in October 2000 (see Chart G). The average time spent in seclusion per episode was 2.66 hours, with a high of 5.7 hours in December 2000, and a low of 1.7 hours in August 2000 (see Chart H).

Chart E

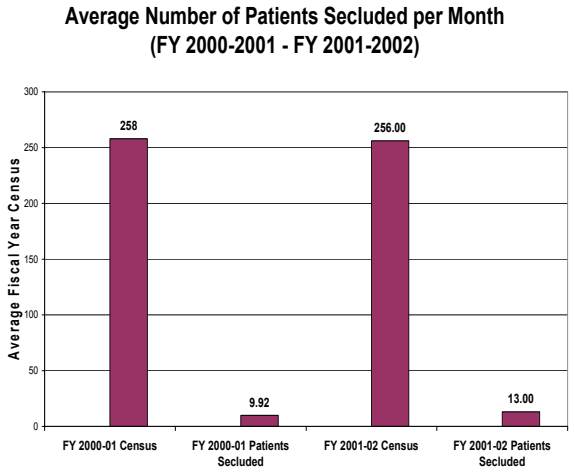


Chart F

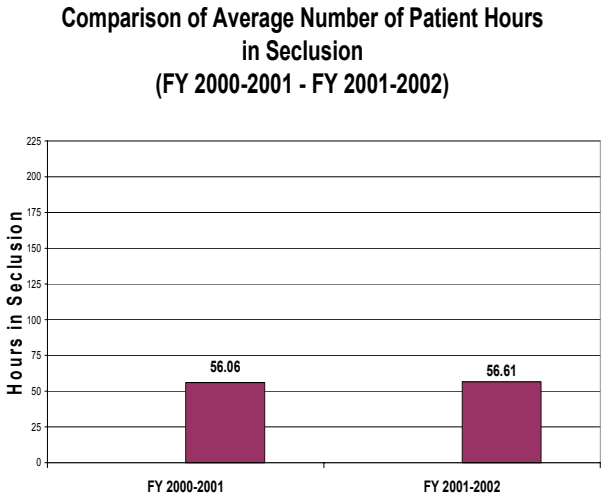


Chart G

Comparison of Average Number of Seclusion Episodes (FY 2000-2001 - FY 2001-2002)

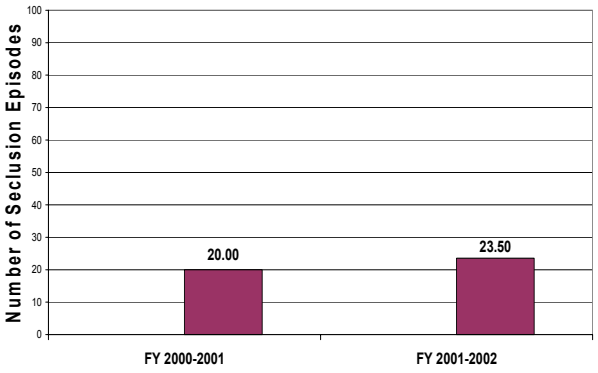
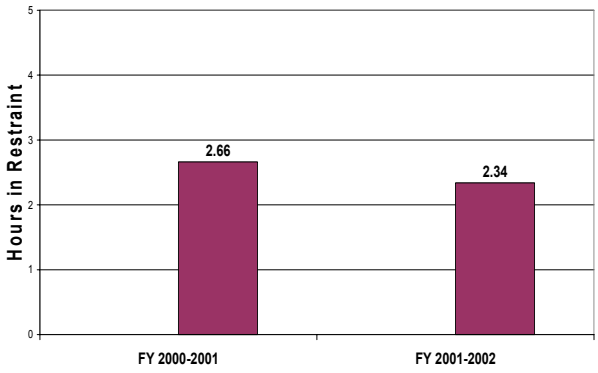


Chart H

Comparison of Average Time Spent in Seclusion per Episode (FY 2000-2001 - FY 2001-2002)



During FY 2001-02, the average number of patients secluded per month was 13 (5.08%), with a high of 24 (9.38%) in December 2001, and a low of 7 (2.73%) in both February and April 2002. The average number of patient hours in seclusion was 56.61 per month, with a high of 169.32 in December 2001, and a low of 19.6 in April 2002. The average number of seclusion episodes was 23.5 per month, with a high of 65 in December 2001, and a low of 8 in February 2002. The average time spent in seclusion per episode was 2.34 hours, with a high of 3.19 hours in February 2002, and a low of 1.63 hours in September 2001.

B. Comparison of Aggregate Data FY 1997-02

	FY 1997-1998	FY 1998-1999	FY 1999-2000	FY 2000-2001	FY 2001-2002
Average % of Census Restrained	16.74	14.71	17.20	15.73	19.06
Average Restraint Hours	1,274.50	415.33	177.70	162.03	211.62
Average % of Census Secluded	7.92	5.81	4.16	3.84	5.08
Average Seclusion Hours	317.33	190.92	78.50	56.06	56.61

Note: FY 2001-02 data is through April 2002.

The data from 1997 through April 2002 demonstrate the upward trend in the areas described earlier. The average percentage of the census with whom restraint has been used has fluctuated within a few percentage points between FY 1997-98 and FY 2001-02 (through April 2002). The current percentage, however, is at its highest level since FY 1999-2000. The average restraint hours decreased significantly each year from 1997-98 through 2000-01. This year, however a sharp increase of 31% was seen over FY 2000, bringing the average restraint hours at WSH to its highest point since FY 1998.

In terms of seclusion, the data show much less fluctuation. The average percentage of the census secluded decreased steadily from FY 1997-98 to FY 2000-01. This year, however, as with the use of restraints, an increase was seen in the average percentage of the census secluded. The increase was 32% and it bears watching to ensure that an upward trend does not continue. Average seclusion hours have remained fairly stable since the study period of FY 2000-01 and continue to be lower than the period from FY 1997-98 through FY 1999-00.

C. WSH's Use of Seclusion and Restraint from July to November 28, 2001

Of the 50 incidents of seclusion and restraint reviewed for this report, 26 incidents, or 52%, involved seclusion and 24 incidents, or 48%, involved restraint. The average time spent in seclusion was 2.76 hours, slightly more than the overall average for the year. The high was 12 hours spent in seclusion; the low 15 minutes. The average time spent in restraints was 7.75 hours. However, one patient stayed in some form of restraints for 144.07 hours[2], and this episode skews the remaining results. When this patient is removed from the

[2] This patient was very agitated upon admission and, by his own admission, quite psychotic and out of control. He has a long history of aggression, including severe self-mutilation involving the amputation of body parts. Upon admission, he asked to be placed in restraints, and attacked another patient after being placed in ambulatory restraints. He was asked throughout the period of restraints if he felt safe to be released, and he often asked not to be released. Although he felt ready for release sooner than his actual release, he respects the team's decision to release him slowly through a series of step-downs to less restrictive methods.

equation, the average time spent in restraints was 2.2 hours, again slightly higher than the overall average cited above as 2.07 hours, with a high of 5.5 hours and a low of 1.5. These data relate only to the use of restraints not used merely to transport the patient to another form of seclusion or restraint.

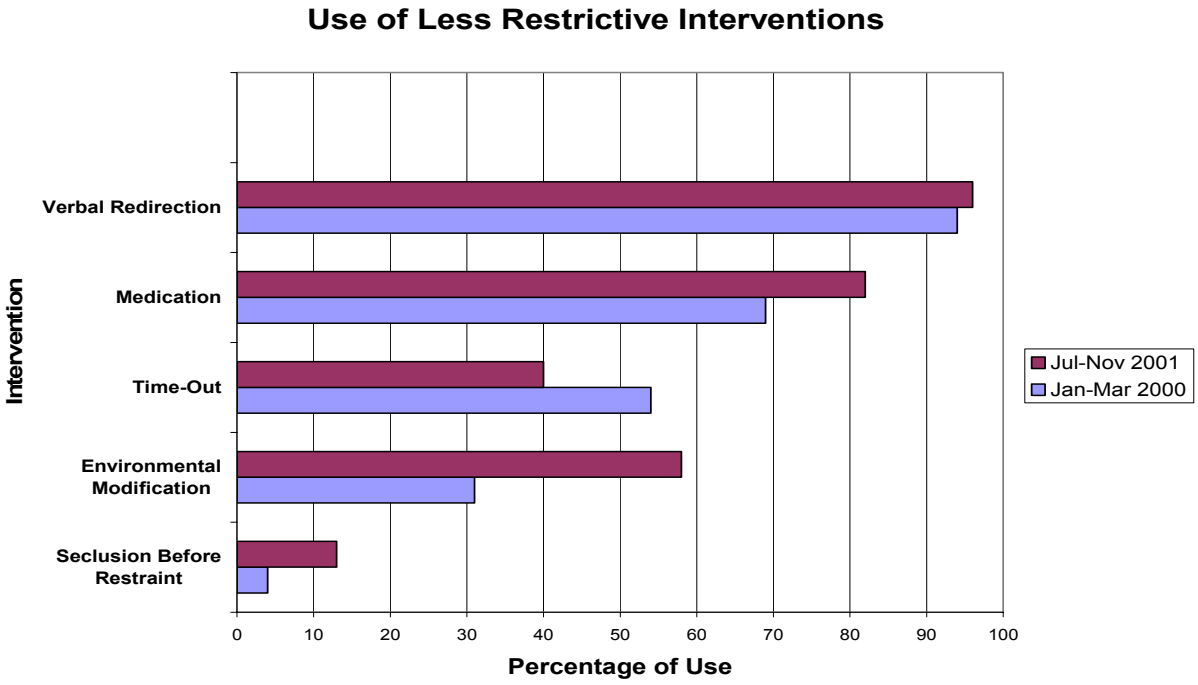
D. Areas of Improvement

WSH has shown significant improvement in two major areas of concern identified in VOPA's initial report.

(1) Use of Less Restrictive Interventions Before Using Seclusion or Restraint

Less restrictive techniques were used with more consistency during this current study period. Verbal redirection was tried in 96% of those cases where the dangerousness of the incident allowed it. This number is a small increase from the initial report that documented verbal redirection in 94% of cases. Similarly, the use of PRN (as needed) medications increased to 82% as compared to 69% in the previous report. A change of environment or removal of the individual from the source of the agitation was utilized in 58% of cases compared to 31% in the initial report. In restraint cases, seclusion was attempted first in 13% of cases compared to 4% during the previous study period. The only intervention that was used less frequently than in the previous report was that of time-out, used in 40% of cases examined in the follow-up study, compared to 54% in the initial study (see Chart I).

Chart I



(2) Use of Least Restrictive Methods When Patient is in Restraint

WSH has improved in its use of less restrictive restraint methods. VOPA's initial study found that WSH used 4-point-to-bed restraints (one of the most restrictive methods) the most often—in 44% of cases. The current data indicates that the most widely used method of restraint is 4-point-to-chair, a less restrictive method, which was used in 33.33% of cases (compared to 20% previously). The 4-point-to-bed restraints were used 29.17%, a decrease of 12%. There were no incidents of the use of 6-point-to-bed restraints in this study, whereas this most restrictive method was used in 8% of cases studied in the initial report.

E. Areas of Concern

Despite the improvements noted, areas of concern remain, particularly those in which WSH violates policy and the rights of its patients. The first noted area of concern is

new. The other two are concerns that were noted in our earlier study report and need further review and action by DMHMRSAS.

(1) Increase in the Use of Seclusion and Restraint Methods Since the Initial Report

As long as seclusion and restraint is used, there will be concerns about it. While WSH has made real and commendable improvements in the way it uses seclusion and restraint methods, questions persist regarding both the need to use it and the way it is used. As can be seen by examining the aggregate data reported herein, WSH's use of seclusion and restraint methods has increased since VOPA's initial report. While it is beyond the scope of this report to examine the reasons for the increase, any increase is troubling.

During the time in which WSH has increased its use of seclusion and restraint methods, the Commonwealth of Pennsylvania, using methods detailed in VOPA's initial report, has practically eliminated the use of seclusion and restraint. Pennsylvania has accomplished this by extensively training its hospital personnel and rigidly requiring that staff follow its seclusion and restraint policy, which, as detailed in the initial report, is very similar to WSH's. WSH is therefore strongly encouraged to emulate the efforts made by Pennsylvania and to further reduce its reliance upon and use of seclusion and restraint methods.

(2) Unwarranted Use of Seclusion and Restraint

WSH is commended for reducing the number of instances when seclusion and restraint methods were used when not warranted. VOPA found only one such instance in this study, as opposed to finding unwarranted use in 23% of cases (8 instances) in its initial study. However, any unwarranted use of seclusion and restraint methods is dangerous and, more importantly, violates the rights of the

patient. In the case identified by VOPA, a patient exhibited intermittent periods of anger and aggression during a twenty-four hour period, including exhibiting behaviors that may have met the criteria for the use of seclusion and restraint. However, WSH did not institute seclusion until several hours after the patient stopped exhibiting such behaviors. The patient's records indicate, undeniably, that seclusion was unwarranted and gave rise to an inference that it was used, in this case, to punish the patient for his earlier behavior. VOPA cannot stress enough that such incidents should never occur. They violate WSH's policy, are dangerous to patients, and have no therapeutic value.

(3) Communicating with Patients

One of the most significant lingering areas of concern is WSH's continuing failure to communicate with its patients, as required by its policy, during and after the use of seclusion and restraint methods. In its initial report, VOPA recommended that WSH, consistent with its own policy, communicate with patients who are in seclusion or restraint, inform them of the behaviors they must exhibit in order to be released and "debrief" them after they are released. In this way, patients can grow to understand and avoid the behaviors precipitating the use of seclusion and restraint methods.

The data reviewed by VOPA for this report, however, indicate that patients were informed of release criteria in only 50% of the cases studied, a 13% decrease from the initial study in which lack of communication was noted to be a serious problem. Additionally, the data show that WSH offered to discuss the incident with patients in only 14% of the incidents.

This continuing failure to communicate with patients blatantly violates WSH's policy and the rights of its patients. WSH staff must follow WSH policy and communicate release criteria to patients and, upon release, discuss the use of seclusion and restraint with the patient. Without such communication, the use of seclusion and restraint methods is merely a tool for patient punishment and staff convenience. If the use of seclusion and restraint methods is to have any therapeutic value, patients must understand the behaviors that resulted in, and will terminate, its use. Patients must be partners in their treatment; but the only way such a partnership can exist is if staff communicate with them. Without adequate communication, patients will continue to be "acted upon" rather than "active participants."

CONCLUSION

WSH's reduction in their reliance upon and use of seclusion and restraint methods can be viewed as a "work in progress." When viewed in this light, WSH is to be commended for the progress it has made over the last 5 years. WSH has increased the use of less restrictive alternatives to seclusion and restraint and decreased its use of the most restrictive seclusion and restraint methods. However, real and persistent concerns remain regarding WSH's use of these methods and the upward trend in the use of seclusion and restraint, particularly restraint, is disturbing and should be very closely examined and addressed. WSH must continue to decrease its use of and reliance upon these methods, rigidly enforce its policy, and ensure that these methods are used only when absolutely warranted. WSH should also closely examine the strides made by other states such as Pennsylvania, which have been successful in drastically decreasing, if not eliminating, the use of seclusion and restraint.

Dated: April 21, 2003

Respectfully submitted,
Commonwealth of Virginia
Virginia Office for Protection and Advocacy
202 N. 9th Street, 9th Floor
Richmond, VA 23219
(804) 225-2042

BY:

_____
Jonathan G. Martinis
Managing Attorney, PAIMI Program

_____
Dana W. Traynham
Staff Attorney, PAIMI Program

_____
Michael R. Gray
Staff Attorney, PAIMI Program

_____
Paul J. Buckley
Staff Attorney, PAIMI Program

EXHIBIT 1

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dmhmrsas.state.va.us

April 11, 2003

Jonathan G. Martinis, Esquire
Virginia Office for Protection and Advocacy
Ninth Street Office Building
202 North 9th Street, 9th floor
Richmond, VA 23219

Dear Mr. Martinis:

Thank you for sharing the Draft Follow-Up Report on the Use of Seclusion and Restraint at Western State Hospital (WSH). The Department appreciates the diligence with which your office guards the rights of our clients. Even though the Department monitors seclusion and restraint in its individual facilities, an independent review is always enlightening.

I also appreciate your recognition of the great strides that the staff of WSH has made in the area of seclusion and restraints. Even though the use of seclusion and restraint may have increased, the appropriateness of that use, the adherence to policies and procedures and the use of alternative interventions prior to the initiation of seclusion or restraint, have all shown great improvement. The Department agrees that seclusion and restraint should always be the intervention of last resort.

Your report notes three areas of concern with regard to WSH's use of seclusion and restraint: 1) the increased use of seclusion and restraint, 2) unwarranted use of seclusion and restraint, and 3) communicating with the clients during and after the seclusion or restraint episode. I welcome the opportunity to respond to these concerns.

In general, you will be pleased to know that the Department is initiating a program to reduce the use of seclusion and restraint system-wide. This will be done through the implementation of individualized behavior management plans that focus on decreasing the use of all types of coercive techniques and increasing the use of techniques that empower our clients to make good decisions and increase their repertoire of appropriate responses. The Department is also implementing a new seclusion and restraint automated data system to improve the quality of reports and focus on areas within specific facilities that may require improvement.

While it is impossible to say exactly why the hours of seclusion and/or restraint have increased and while the Department agrees that it does look like a disturbing trend at first glance, it may well be that as more clients are being served in the community and in private facilities, only those clients who pose such severe behavior problems that they cannot be managed in the community are being served in the state facilities. This increase in the use of seclusion is accompanied by an increase in the appropriate use of these techniques, pointing to the theory that the clients being served may be more behaviorally challenged than in past studies.

We agree that any use of restraints or seclusion in an inappropriate manner is to be avoided. The finding that in 98% of the cases restraints or seclusion was used appropriately is heartening and testifies to the staff's belief in not using restrictive measures unless absolutely required. Monitoring of the appropriate use of seclusion and restraint and further education in behavior management techniques will assure that this decrease in inappropriate use continues.

Communicating and debriefing with clients relative to their seclusion or restraint episode is an area that the Department will encourage WSH to track through the new seclusion and restraint documentation program to start as of July 1, 2003. This can be done by adding additional fields for analysis. This should assist WSH in more thoroughly internally monitoring seclusion and restraint. WSH also has a new Clinical Nurse Specialist who has met with the various treatment teams to begin an education program in interaction techniques and will address the need for communication of conditions for release and debriefing after the episode.

I agree that it will be useful in connection with our newly initiated system-wide efforts in reducing seclusion and restraint to also review the successes of other states. Again, let me express my appreciation of the work done by your agency in seeking to ensure clients rights, in acknowledging WSH's areas of improvement, and in making recommendations in areas that may still need improvement.

Sincerely,

James S. Reinhard, M.D.

pc: Jerry Deans, Assistant Commissioner Facility Management
James Evans, M.D. Medical Director
Jack Barber, WSH Facility Director
Rosemarie Bonacum, Director Facility Operations/Quality Improvement